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AUTHOR Tramonte, Michael R.
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ABSTRACT

The rapid increase in the United States' racial and ethnic minority populations has accompanied a mental health revolution. Traditional models previously used to explain normality and abnormality are being questioned. Therefore, ways in which school psychologists can become more aware of their own cultural background, and thus provide caring, sensitive, and responsive mental health diagnostic services to those from other cultures, is the focus of this paper. Tips counselors can use to develop cultural competencies in awareness, knowledge, and skill are explored first, followed by a detailed analysis of the cultural limitations of using the Diagnostic and Statistical Manual (DSM-IV). It is argued that the DSM-IV incorporates culture into its diagnostic scheme, and since mental disorders exist within an individual who is interacting within a culture and society, it is important to understand cultural influences on diagnostic criteria. Ways in which to improve the DSM-IV's cultural validity, and thus its cross-cultural utility, are examined. Of particular interest is the interaction among religion, spirituality, and the DSM-IV. Some of the cultural limitations in using the Mental Status Examination (MSE) are also explored. Nine appendices feature assessment tools that counselors can use to heighten their awareness of their cultural background. Contains 60 references. (RJM)

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School Psychologists in the Multicultural Environment: Recognizing the Diagnostic Limitations of Using the DSM-IV and the Mental Status Examination

by

Michael R. Tramonte, Ed.D., NCSP
School Psychologist, Lowell Public Schools
Special Education Center, 155 Merrimack Street, 3rd Floor
Lowell, Massachusetts 01852
1-(508) 937-7685 or 1 (508) 937-7608

and

Adjunct Instructor in Psychology
Middlesex Community College
Bedford, Massachusetts 01730

and

Senior Lecturer in Educational Psychology
Rivier College
Nashua, New Hampshire 03060

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M. Tramonte

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> From a general standpoint, psychiatric illnesses are human behavior anomalies and breakdowns that are culturally shaped, explained, and dealt with in terms of established conventions and meanings. Societies differ greatly in terms of how they define and explain such breakdowns (Fabrega, 1996, p. 3)

Because of a rapid increase in U.S. racial and ethnic minority populations, multicultural psychology has emerged as a current trend. The United States has undergone some rapid demographic changes referred to as the "diversification of the United States." According to Sue, Sue, and Sue (1997), more than one-third of the population will be members of racial or ethnic minorities in the year 2000; and within a few decades, European Americans will be in the numerical minority (p. 59). This cultural diversity has caused a mental health revolution and a change in the traditional models used to explain normality and abnormality. Besides the traditional biogenic paradigm, and the psychosocial perspectives (psychoanalytic, humanistic existential, behavioral, cognitive, and family systems), there is now the psychosocial multicultural viewpoint.

Sue, Sue, and Sue (1997) identify the "culturally pluralistic model" in the following way:

> To be culturally different does not equal deviancy, pathology, or inferiority. Each culture has strengths and limitations and their differences are inevitable. Behaviors must be evaluated from the perspective of a group's value system as well as other standards used in determining normality and abnormality (p. 62).

Sue, Sue, and Sue (1997, p. 62) share four assumptions of the "culturally diverse model:"

(1) Culture is central to all theories of pathology and failure to acknowledge this fact leads to inaccurate diagnosis and treatment.
(2) European American conceptions of mental health must be balanced by non-Western perspectives.
(3) Human development is embedded in multiple levels of experiences-- individual, group, and universal--and in multiple contexts, including individual, family, and cultural milieu.
(4) A metatheoretical approach (a theory about theories) to models of pathology may yield the most fruitful results.

When functioning as health care providers in a multicultural environment, school psychologists, in assessing and diagnosing mental disorders, need to be aware of three possible inaccurate consequences: overdiagnosis, underdiagnosis, and

misdiagnosis. To prevent such problems, Flaherty et al. (1988, pp. 257-263) recommend culture-free tests that must fulfill five validity criteria which, in reality, no test does:

(1) Content equivalence (Are items relevant for the culture being tested?)
(2) Semantic equivalence (Is the meaning of each item the same in each culture?)
(3) Technical equivalence (Is the meaning of each item the same in each culture?)
(4) Criterion equivalence (Would the interpretation of variables remain the same when compared with the norm for each culture studied?)
(5) Conceptual equivalence (Is the test measuring the same theoretical construct across cultures?)

Besides knowing about validity criteria, school psychologists also need to be cognizant of ten guidelines to minimize bias when assessing multicultural individuals. Paniagua (1994, pp. 106-107) lists them as follows:

(1) The practitioner should examine his or her own bias and prejudice before engaging in the evaluation of clients who do not share the practitioner's race and ethnicity.
(2) The practitioner should be aware of the potential effects of racism.
(3) The practitioner should include an evaluation of socioeconomic variables and use them.
(4) The practitioner should try to reduce the sociocultural gap between the client and himself or herself.
(5) The practitioner should include an evaluation of culturally related syndromes.
(6) The practitioner should ask culturally appropriate questions.
(7) The practitioner should consult paraprofessionals and folk healers within the particular multicultural groups.
(8) The practitioner should avoid the mental status examination.
(9) The practitioner should try to use the least biased assessment strategies first, then consider the most biased strategies under special circumstances.
(10) The practitioner should use Dana et al's (1993) assessment model as an overall approach to minimizing biases.

Two of Paniagua's (1994) guidelines will be integrated into this workshop: (1) the school psychologist's self-awareness of cultural bias and (2) the diagnostic and cultural limitations of using the mental status examination (MSE). In addition, difficulties with employing the DSM-IV will be considered. Also, competencies of multicultural counseling will be explored. Although not mainly intended for assessment, the competencies can be related to it

Introspective Exercise

By becoming aware of how their own cultural background (experiences, attitudes, values, and biases) influence their interactions with multicultural individuals, school psychologists will be able to enhance their skills in providing caring, sensitive, and responsive mental health diagnostic services to multiethnic children, adolescents, and others. Knowing oneself is a prerequisite to effective interpersonal helping.

According to Singelis (1994), research has shown that "up to 93% of the social meaning of a message is carried via nonverbal channels" (p. 268). Because of the importance of nonverbal communication, school psychologists, in making DSM-IV or mental status diagnostic observations, need to be aware of its components. Jandt (1995) identified ten categories: "signs and symbols, proxemics, kinesics, chronemics, paralanguage, silence, haptics, clothing and physical appearance, olfactics, and oculesics" (pp. 75-87). Because nonverbal communication is often minimized or neglected in intercultural communication training workshops, school psychologists will be presented with a nonverbal communication exercise that will help them reflect. The complete self-assessment includes 15 statements (Singelis, 1994). For the purpose of this workshop, ten will be presented. A few will be modified (Appendix A).

Hughes (1993) identifies eight questions that school psychologists can ask in preventing themselves from projecting their own ethnocentric assumptions and standards into the treatment setting (Appendix B).

Developing Cultural Competence

The American Psychological Association identified a three-level developmental competency of multicultural counseling. The categories are: awareness, knowledge, and skill. Even though they apply to counseling, they are presented here with the word "assessment" substituted by this writer where the term "counseling" was used. According to Pedersen (1994, p. 233), they include:

Awareness:

(1) To become aware of one's own culture.
(2) To become aware of how one's values might affect clients.
(3) To become comfortable with cultural differences.
(4) To know when a culturally different person should be referred.

Knowledge:

(1) To understand the sociopolitical dynamics between majority and minority cultures.
(2) To have knowledge about a client's culture.
(3) To have knowledge about traditional and generic assessment theory and practice.
(4) To know institutional barriers to multicultural assessment.

Skill:

(1) To generate a wide variety of verbal and nonverbal responses for different cultural settings.
(2) To send and receive verbal and nonverbal messages accurately across cultures.
(3) To advocate for change of the system when necessary.

Cross et al. (1989, pp. iv-v) embraced cultural competence as "the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs." They identified a six-point cultural competence developmental continuum as a goal to be met. The six areas can be viewed in Appendix C.

Cultural Limitations of Using the DSM-IV

> All people are seen through others' lenses. What is more, these stereotypes are almost always based on gender as well as the cultural values (Nadelson & Zimmerman, 1993, p. 501).

Before discussing the cultural cautions in using the DSM-IV, it is important to share how it incorporates culture into its diagnostic scheme. The psychiatric manual recognizes that mental disorders exist within an individual interacting within a culture and society. Pederson (1996, p. 53) identifies DSM-IV's path to the social context of mental disorder. The approach is presented verbatim below:

(1) In contrast to earlier editions of the DSM systems which either ignored culture altogether or made minimal reference to it, DSM-IV tries to recognize that problems exist within people who in turn exist within a society and a culture.

(2) The diagnostician is reminded to approach each individual in the context of their culture (social context).

(3) The term 'mental disorder' is difficult to define and lacks precise boundaries. {Appendix D} illustrates the 'Epistemology of the Diagnostic Endeavor' taken from Frances, First, & Pincus (1995).

(4) If a way of behaving is expected and sanctioned within a culture, then it cannot be regarded as a mental disorder, no matter how much distress or disability it seems to involve.

(5) Disorders are to be diagnosed, not individuals per se and certainly not entire societies or cultures.

(6) Consider that all social groups have accepted ways of behaving and that these may differ markedly.

(7) DSM-IV cautions the diagnostician not to misinterpret a conflict that an individual may have with larger social institutions as a mental disorder unless the conflict is clearly the result of something problematic within the person (as opposed to within the society; for example, political dissent).

(8) DSM-IV in its discussion of clinical syndromes, attempts where possible to explain how a problem manifests itself in different cultures.

(9) Various culture-bound syndromes are also described.

Based on the medical model, DSM-IV has improved on two of its diagnostic features: operational criteria and multiaxial diagnoses. Its biological model is now more biopsychosocial than it has ever been. For example, Lewis-Fernandez (1996) reported that the NIMH Culture and Diagnosis Group was formed and "tested the applicability of the Cultural Formulation on the four main ethnic minorities in the United States" ---African (or Black) Americans, Native Americans (or American Indians), Asian Americans, and Latinos (or Hispanic Americans). "Results revealed that the Cultural Formulation could be used very successfully as currently proposed" (p. 136).

Good (1996b), in sharing an assessment by the NIMH Culture and Diagnosis Group which submitted proposals and tried to influence DSM-IV, identifies the DSM-IV's cultural contributions and weaknesses:

> On the one hand, cultural concerns are represented in the introduction, in the introduction to the multiaxial structure, in the text associated with particular categories (as 'cultural considerations'), in a glossary of cultural terms (culture-bound syndromes and idioms of distress), and in an outline of an approach to culturally sensitive assessment appearing in one of the Appendices of DSM-IV. All is an advance.
>
> On the other hand, many of the substantive recommendations made by the task force--the wording of particular symptom criteria, variations in duration criteria, widespread evidence for new or revised categories (a mixed anxiety-depression category, culturally distinctive forms of dissociative disorders, neurasthenia as seen and diagnosed in many Asian cultures)--were not incorporated into the body of the diagnostic manual, in spite of strong empirical data from the cross-cultural research literature. The primary focus and philosophical commitments of the DSM-IV remain largely impervious to the empirical and ultimately political claims of those at the cultural margins of American society (p. 348).

According to Good (1996b, p. 348), "Any diagnostic system is culturally situated; there can be no 'God's eye point of view' free of culture from which to assess a person suffering a mental illness." Therefore, although DSM-IV's cultural sensitivity is a marked improvement over earlier editions, it is not culture-free. The manual's content

is based on Western-industrialized cultural experiences and may not be reflective of the types and expressions of psychopathology in other cultures (Neale, 1996). Nevid et al (1997) stated that the DSM-IV was approved by United States' trained clinicians. As a result, if Asian-trained or Latin American trained professionals were included in the consensus process, the DSM-IV mental disorders and criteria would be different. Manoleas (1994) reported that the manual represents Euro-American and not Third World values.

To contribute to DSM-IV, a Coordinating Group for the Task Force on Culture and DSM-IV met for over 2 years. It emphasized cultural critiques of DSM-III-R, changes in the content, and to a lesser degree changes in the form (such as adding the Cultural Formulation). DSM-IV only incorporated a small percentage of the recommendations. In the following criticisms, Kleinman (1996) shares the first critique while Lewis-Fernandez and Kleinman (1995) add the second and third:

> Regrettably, even though DSM-IV has many more things to say about culture, few of the really crucial recommendations that our panel made were included. Therefore, much of what DSM-III-R was criticized about holds for DSM-IV too (p. 21).
>
> This pattern of decisions denotes a general policy. It suggests that the editors of DSM-IV may not really be interested in the cultural validation of the Manual and seem unwilling to accord the same serious consideration to cultural data as is given to other data sources (p. 439).
>
> It is clear that the recent theoretical and research changes in cultural psychiatry outlined in this review have not permeated the leadership of US psychiatry. The most significant recent clinical development in cultural psychiatry in North America, therefore is, in these authors' opinion, the failure of the cultural validation of DSM-IV (p. 439). Why? (See Appendix E).

To discover other cautions in using DSM-IV cross-culturally, this school psychologist researched the literature. Many were located, but sixteen of them were chosen and will be presented verbatim:

1. Some categories may be valid in other cultures while others may not be (Nevid, 1997, p. 81).

2. Psychological distress may be experienced differently in various cultures. For example, a Hispanic culture-related syndrome <u>ataque de nervios</u> is similar to a panic attack in the United States (Nevid, 1997, p. 81).

3. Clinicians are not free from prejudice and bias regarding qualities such as race, sex, and socioeconomic status. Diagnosticians are more likely to give certain diagnoses to patients whose sex, race, and socioeconomic status conform to their

expectations about the kinds of people who have such disorders. This can cause misdiagnoses, overdiagnoses, or underdiagnoses (Wilson, 1996, p. 77).

4. Language differences and different subcultural norms for behaviors and experiences also complicate the evaluation of minorities. These complications can result in clinicians' minimizing problems (as when a symptom of a psychological disorder is written off as normative within the minority patient's subculture) or overpathologizing (as when a normal difference from the majority culture is misinterpreted as pathological (Neale, 1996, p. 129).

5. The clinician needs to ask culturally appropriate questions. Paniagua (1994) gives the following examples: Do not ask an Asian client 'What is your opinion of yourself compared with other people?' Instead, Ask, 'Do you like yourself?' Asians do not like to compare themselves with others. Do not ask an Asian client 'Are you angry with your parents?' Instead, inquire 'How is the relationship between you and your parents?' Regardless of the relationship, Asians show respect toward parents (p. 115-116).

6. When a client uses a second language to express his or her thoughts and feelings, the clinical findings may be distorted. The results could be accentuated or minimized (Westermeyer, 1993, p. 128).

7. 'Proxemics,' the study of social and interpersonal nonverbal behavior,' varies from culture from culture. This can cause distortions also in the diagnostic formulation (Westermeyer, 1993, p. 129).

8. 'Pathoplasticity' refers to 'the variable manifestations of a given pathological process.' For example, 'psychotic delusions across cultures are constant in form (e.g., paranoid, grandiose, and somatic) but pathoplastic in content.' 'Whites may fear that the Mafia or the CIA is after them; Asians may believe that an ancestor ghost is tormenting them' (Westermeyer, 1993, pp. 133-134).

9. The clinician needs to be aware of cultural transference (the client's feelings toward the clinician's ethnic group) and cultural countertransference (the clinician's feelings and attitudes toward the client's culture) (Westermeyer, 1993, p. 135).

10. Although class status and ethnic identity influence the experience of mental illness, it is important to avoid group generalizations or stereotypes. Individuals within a cultural group may share differences as well as similarities (Kaplan & Sadock, (1991, p. 131).

11. The practice of the psychiatrist is culturally patterned. A psychiatric diagnosis, after all, is an interpretation of an interpretation . . . What the patient reports, is, itself an interpretation of experience based on his or her own cultural categories, words, images, and feelings for expressing (and thereby constituting) symptoms.

The psychiatrist's interpretation occurs one remove further(Kleinman, 1996, p., 19).

12. The mind-body dichotomy that looms behind the somatoform disorders; the pathogenetic-pathoplastic division implicit in the major mental disorders; the idea of single, stable personalities as socially normative and personally normal, which underwrites both the dissociative disorders and Axis II--all are examples of DSM-IV's powerful orientation to Western cultural values (Kleinman, 1996, p. 20).

13. DSM-IV is a product of the Western academic conventions about rationalism, voluntarism, and autonomy. These conventions of personhood are implicit in the DSM-IV system (Fabrega, 1996, pp. 8 & 12).

14. The members of many non-Western societies and traditionally oriented ethnic groups regard the person as more sociocentric than egocentric; the boundaries of the ego as permeable; and the self (or soul) as fluid and capable of leaving the body, entering altered states, and becoming possessed. These alternative ideas are basic to the mental health categories of traditional Chinese, Indians, Southeast Asians, and members of African and South American groups, who together constitute more than three fourths of the world's population. Thus, the cultural influences on DSM-IV is not only apparent but represents a minority bias cross-culturally (Kleinman, 1996, p. 20).

15. There is no life events scale that includes racial/ethnic discrimination as a major and/or continuous stressor for minority group children or adults. In this respect, minority group children are invisible in the DSMs, and the psychosocial stress that impinges on their development and their mental health is rarely considered in the diagnostic process. The consequences of this oversight are many and include erroneous diagnoses and inadequate treatment (Johnson-Powell, 1996, p. 272).

16. DSM-IV's categories are written in such a way as to make it seem that there can be no major variations in health and human development; yet the empirical record tells exactly the opposite story. Variations are the rule across societies with respect to normal and abnormal psychological processes and child development (Kleinman, 1996, p. 20).

Steps Toward a More Culturally Valid DSM-V

Kleinman (1996, pp. 21-24) identified eight steps to improve DSM-IV's cultural validity and therefore cross-cultural utility. The major point of each step toward a future culturally valid DSM-V is cited here:

1. DSM-IV's introduction includes a longer and more specific set of guidelines concerning the use of DSM with members of ethnic, refugee, and cross-cultural groups in both domestic and international settings. These guidelines discuss expectable problems. Practical strategies should be described that can be used to overcome

these problems. Also, the section on cultural assessment should be moved out of the Appendix and into the Introduction.

2. It should be officially debated whether it is useful and feasible for a cultural axis to be added to assess degree of acculturation, likelihood for cultural obstacles, and particular types of cultural bias.

3. Under each disease condition or chapter, there should be a section on cultural issues in diagnosis that includes specific culturally relevant inclusion and exclusion criteria and discussion of cultural influence on symptoms, illness behavior, course, and risk factors. At present, most of what DSM-IV says about culture under most diseases is not crucial for diagnosis and treatment. In DSM-V, that needs to change.

4. For dissociative disorders (as well as other mental disorders that are particularly common and significant cross-culturally), specific examples should be given of common symptoms and behaviors cross-culturally. Because dissociation occurs in more than 95% of the world's cultures and is most often normative and normal though it also can express psychopathology, differentiating normal from abnormal dissociation is crucial.

5. Appendix to DSM-IV lists the common cultural idioms of distress and culture-bound syndromes for major ethnic minorities and refugee groups in the United States and should be moved to the text itself.

6. An Appendix should also include a list of expectable problems in working with interpreters and how to prevent them.

7. Each section of the DSM Case Book should contain illustrative cross-ethnic and cross-cultural cases. Alternatively, an argument could be made for a separate casebook for ethnic and cross-cultural cases, because clinicians learn best from case examples.

8. The introduction to DSM-IV defines and explains culture and ethnicity so that it is clear that cultural groups are heterogeneous owing to gender, age, subethnic grouping, social class, and lifestyle. In DSM-V, emphasis should be extended to the appreciation of how the culture of biomedicine and the institutional cultures of professional practice influence practitioners' own perspectives and actions.

Guarnaccia (1996) also recommends an additional axis, a cultural axis, which can be used as a central aspect of diagnosis. It could include three areas:

(1) the assessment of language abilities and preferences of multilingual individuals;
(2) the assessment on a unidimensional scale of an individual's affiliation on a continuum from totally involved in their culture of origin to totally assimilated to the host culture known as the area of acculturation, biculturalism; and
(3) the sorting out of those ideas that are culturally consonant and those that are

indicative of disorder which requires an assessment by the clinician and significant others of the role of religion in the person's life and the degree to which a person's ideas are culturally appropriate (pp. 336-337).

Alarcon (1995) reports on how culture influences the five DSM-IV multiaxial system: (Appendix F).

Religion, Spirituality, and DSM-IV

Kleinman (1996, p. 24) stated that "a serious interest in the patient's culture means a more sophisticated and sensitive engagement with religious values than psychiatrists generally demonstrate. Ninety percent of North Americans express a belief in God, and more than 75% pray to God for assistance, so that even in this 'secular' society, the perceived teleology of the experience of suffering is likely to be articulated in religious terms that affect the illness and its treatment."

For the first time in any of the DSM's, there is a new category, "Religious or Spiritual Problem" (V62.89). This new classification "acknowledges that religious and spiritual problems can be a focus of mental health consultation and treatment without being attributable to a mental disorder" (Lukoff, Lu, & Turner, 1995, p. 469). This is a step in the right direction. It may be helpful for school psychologists to be familiar with both the types of religious and spiritual problems they might encounter. According to Lukoff, Lu, & Turner (1995), examples of religious problems include loss or questioning of faith, change in denominational membership or conversion to a new religion, intensification of adherence to beliefs and practices, and new religious movements and cults. Illustrations of spiritual problems involve mystical experience, near-death experience, spiritual emergence/emergency, meditation, and medical/terminal illness (p. 469).

Paniagua (1994) devised a rating scale to help practitioners examine their own biases and prejudices of four multicultural groups and the dominant white culture. The included groups are African Americans, American Indians, Asians, Hispanics, and Whites. For the purpose of this school psychologist workshop, the "Self-Evaluation of Biases and Prejudices" is used as a base but is somewhat modified (Appendix G).

Cultural Limitations of Using the Mental Status Examination (MSE)

Kaplan & Sadock (1991) describe the mental status examination (MSE) as follows:

> The MSE is the part of the clinical assessment that describes the sum total of the examiner's observations and impressions of the psychiatric patient at the time of the interview. Whereas the patient's history remains stable, the patient's mental status can change from day to day or hour to hour. The MSE is the description of the patient's appearance, speech, actions, and thoughts during the interview. . . Although practitioners' organizational formats for writing up the MSE vary slightly,

formats must contain certain categories of information (pp. 200-201).

Kaplan & Sadock (1991, p. 201) outline one such format:

I. General Description: Appearance; Behavior and Psychomotor Activity; Attitude Toward Examiner.
II. Mood and Affect: Mood: Affect; and Appropriateness.
III. Speech: Quantity; Rate of Production; and Quality.
IV. Perceptual Disturbances: Hallucinations; Illusions; Depersonalization; Derealization.
V. Thought: Process or Form of Thought; Content of Thought.
VI. Sensorium and Cognition: Alertness and Level of Consciousness; Orientation; Memory; Concentration; Abstract Thinking; Fund of Information and Intelligence.
VII. Impulse Control: Control of Sexual, Aggressive, and Other Impulses.
VIII. Judgment and Insight: The Client's Understanding and Awareness of the Likely Outcome of His or Her Behavior? The Degree Whereby the Client Is Aware That He or She Is Ill?
IX. Reliability: The Clinician's Impressions of the Client's Reliability and Capacity To Report His or Her Situation Accurately.

"Diagnosis is more than nosological pigeon-holing. The psychiatrist needs to render a provisional evaluation of the diagnosis, prognosis, client dynamics, and treatment issues" (Kaplan & Sadock, 1985, p. 487). Peterson (1996) reported that the various components of the MSE may be asked directly or observed by the way the client responds to other questions. Although school psychologists may use the MSE, part of it, or none at all, they need to be aware of its cultural limitations as a diagnostic instrument since they may be sent psychiatric reports which are based on it. The components of the MSE are based on the Euro-American culture. Yet, as has already been described in this paper, the United States is becoming more and more multicultural from the Third World. Hughes (1993), Mueller, Kiernan, & Langston (1992), and Westermeyer (1993) encourage clinicians to avoid using the MSE for multicultural individuals. Some cultural limitation examples described by Paniagua (1994, pp. 117-119) are cited here to increase the cautionary awareness of school psychologists:

1. The Assessment of Concentration and Vigilance - Avoid the Serial 7s Tests. Many members of multicultural groups would fail because they are not versed in the area of counting forward or backward.

2. The Assessment of Orientation - When asked 'What is your last name?', a Hispanic client with a last name from the father and one from the mother may become confused having to decide which name to report. Also, when requested to give the name of the month in Standard American English or the name of the building that the person is in, the individual may not be familiar with each or both.

3. The Assessment of General Knowledge - Asking questions such as 'What are the colors of the American flag?' 'How far is it from Houston to Chicago?' or 'Who was the last president of the United States?' imply geographical and public knowledge. Multicultural individuals may not have such information because they may be too poor to travel or may be illiterate.

4. The Assessment of Thought Processes - Although thought blocking (a sudden cessation of thought or speech) may suggest schizophrenia, depression, and anxiety, individuals not fluent in English may show such blocking. They may need a long time to think of the correct word to say. For example, African Americans may use black English in conversation but may have difficulty in thinking of the words in Standard American English. Also, avoid proverbs which deem interpretation. They are culture-bound. In addition, clients may respond to or say 'Evil spirits possess me at times' or 'I am being plotted against.' The clinician may consider such statements as paranoid or schizophrenic symptoms. However, some African Americans and Hispanics may endorse such beliefs. They may believe in evil spirits, witches, and harmful supernatural powers. Too, refugees who survived trauma may feel insecure and paranoic in an 'alien social context.'

5. The Assessment of Appearance - In the United States, lack of eye contact, failure to stare directly into the therapist's eyes, and careless or bizarre dressing and grooming could point to signs of psychiatric disorders. Many Asian Americans and many African Americans avoid eye contact because they have learned it is impolite to look directly into another person's eyes. The therapist may have a different definition of what is normal dressing and grooming. A client may come directly to the therapist in dirty work clothes as weli as a soiled face, hands, and nails after laboring all day.

6. The Assessment of Affect - Culture structures the expression of affect. For example, many Native Americans or Asians may express an impassive facial demeanor while Mediterranean groups may be ebullient. The clinician needs to be aware of such differences.

Alarcon (1995) also issues a cautionary statement and shares similar concerns:

> Much in the same way as the different axes of DSM-IV ought to be examined critically from the cultural perspective, items from the traditional Mental Status Examination (MSE) taught to medical students and psychiatric residents also should sustain a close cultural scrutiny. Appearance, dressing styles, speech modalities, and thought patterns should be seen within the context of culture. Mood also varies on the basis of regional influences and educational levels. In the interpretation of proverbs, concrete thinking looms much as a cultural reflection as a cognitive deficit. The interpretation of symptoms and normal behaviors may follow a noncultural, pathologizing path, and diagnosis and management undoubtedly can be influenced by political, social and economic

considerations (p. 461).

To help school psychologists appreciate why multicultural individuals may have difficulty with the MSE and to help them picture themselves in their place, some questions from Paniagua (1994, pp. 118-119) will be shared (Appendix H). In addition, to assist school psychologists to become more cognizant of how they have been influenced by their culture, some queries will be presented (Appendix I).

In conclusion, it is the hope of this practitioner that this workshop has helped school psychologists to be more sensitive to the recognition of cultural factors in the assessment and interpretation of symptoms. With that awareness, however, school psychologists need to remember also that "cultures are heterogeneous and that any attempt at generalization about a particular cultural group is dangerous" (Locke, 1992, p. xiii) and that there are other influences on personality other than culture. Students need to be understood holistically. Through the use of three statements, Locke (1992) reminds us of assessing the different identities of each person. For the intent of this paper, this school psychologist has changed Locke's declarative sentences to questions:

> How is the person, in some respects, like <u>all</u> other individuals?
> How is the person, in some respects, like <u>some</u> other individuals? and
> How is the person, in some respects, like <u>no other</u> individuals? (p. xiii).

"What these three identities mean for" school psychologists "is that they must be aware that each individual is seeking a personal identity, to a greater or lesser degree, by acknowledging an identity with a cultural group while living in a world community" (Locke, 1992, p. xiii).

Appendix A

Nonverbal Communication Self-Assessment Statements

The following selected ten self-assessment statements are taken from Singelis' (1994) chapter "Nonverbal Communication in Intercultural Interactions." A couple of them have been somewhat modified for the purpose of this workshop. Directions: Assume that in your work as a school psychologist, you deal with many people from cultures other than your own. Answer each statement agreeing or disagreeing with it or selecting "it depends."

1. I can usually tell when there is something bothering the people I interact with because they will usually display a sad or depressed manner.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

2. Since people from all cultures use the same facial expressions to show their emotions, I can usually tell how others are reacting to me.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

3. When a person responds to my question with silence, it usually indicates that the person has not understood what I said but does not want to cause embarrassment to me or him- or herself by asking me to repeat the questions.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

4. What is not said in a conversation is often more important than what is expressed directly.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

5. Laughter always indicates that a person is happy and comfortable.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

6. A person from another culture who doesn't make direct eye contact with me is not paying attention to what I am saying and is also showing disrespect.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

7. The appearance of a person from a different culture is not an important factor in how and what I think about them.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

8. I use a lot of gestures and emphasis in my voice to make points because my foreign language skills are not very good and these nonverbal clues will help me to be understood by people who do not speak my language.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

9. People who have strong body odor are offensive and should be taught proper personal hygiene habits for their own good.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

10. I usually try to keep a conversation active and lively because people will think I am not intelligent, or my language ability is very poor, if I am silent.

1	2	3	4	5
strongly disagree	disagree	it depends	agree	strongly agree

Singelis, T. (1994). Nonverbal communication in intercultural interactions. In R. W. Brislin & T. Yoshida (Eds.), Improving intercultural interactions: Modules for cross-cultural training programs (pp. 269-270). Multicultural Aspects of Counseling Series 3. Thousand Oaks, CA: Sage.

Appendix B

Clinician's Inquiry Into His or Her Own Cultural Bias

1. What about this patient's {student's} appearance or behavior makes me think that what I am seeing and hearing is pathology?

2. What are the sources of the putative "pathologic" characterization?

3. What label(s) am I subconsciously applying to this patient {student}, and where did they come from?

4. What social class or group am I assuming the patient {student} belongs to, and what do I know about that? What are my own prejudices about the group, and where do such characterizations come from--childhood directives and role-modeling, family inculcated out-group attitudes, scanning of current events that may reinforce preexisting stereotypes?

5. Other than "pathology," what other hypotheses come to mind to explain this unusual behavior and/or mentation?

6. What other label could I use to describe this behavior instead of pathology?

7. What are the circumstances of the referral (if referral), and what is the descriptive spoken language used by other health care providers in conveying information about the patient {student}?

8. What labels and summary inferences are used in the patient's {student's} chart or in the referral? How many of the empirical observations such labels purport to reflect can I recreate from the written record (knowing that a medical record needs to be highly selective in the amount of data reported)? What do I know about the person or persons making such comments in the record?

Hughes, C. C. (1993). Culture in clinical psychiatry. In A. C. Gaw (Ed.), Culture, ethnicity, and mental illness , p. 5. Washington, DC: American Psychiatric Press.

Appendix C

Developmental Cultural Competence Continuum

Below are Cross et al's (1989) six-point developmental cultural competence continuum which was abstracted and summarized by this writer. The attitudes proceed from the most negative to the most positive. Where do you fit in?

(1) Cultural Destructiveness - "Attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture" (p. 14). For example, this can involve the process of dehumanizing or subhumanizing minority clients.

(2) Cultural Incapacity - Attitudes involving bias "believing in the racial superiority of the dominant group." The characteristics include "discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients" (p. 15). Segregation is another example.

(3) Cultural Blindness - Attitudes viewing oneself as "unbiased and responsive to minority needs" but in reality embracing "ethnocentricism which is reflected in attitude, policy, and practice" (p. 16). For example, this person believes that traditional dominant culture helping approaches can be universally applicable.

(4) Cultural Pre-Competence - Attitudes "realizing one's weaknesses in serving minorities and attempting to improve some aspect of services to a specific person or population" (p. 16). For example, exploring how to reach minorities in their service area and providing opportunities for cultural sensitivity. A danger here is "tokenism."

(5) Cultural Competence - Attitudes of "acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations." (p. 17). For example, seeking advice and consultation from the minority community.

(6). Cultural Proficiency - Attitudes "holding culture in high esteem and seeking to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects" (p. 17). For example, advocating for improved relations between cultures throughout society.

Cross, T. L. et al (1989, March). Towards a culturally competent system of care (Monograph), pp. 14-17. Washington, DC: CASSP Technical Assistance Center.

Appendix D

Epistemology of the Diagnostic Endeavor

Epistemology is the study of the nature of knowledge. The DSM-IV Task Force was aware of the long-standing debate over how the human mind perceives and constructs our world. It pondered over the views of the following three umpires, each of whom has a very different understanding of the way in which their baseball world is experienced and organized:

Epistemological Umpire I: There are balls and there are strikes, and I call them as they are.

Epistemological Umpire II: There are balls and there are strikes and I call them as I see them.

Epistemological Umpire III: There are no balls and there are no strikes until I call them.

Umpire I expresses the view (labeled as realism in the Middle Ages) that balls and strikes are real entities that exist independently of the mind of the observer.

Umpire III expresses the diametrically opposite view (labeled as nominalism) that balls and strikes do not have any independent reality outside the mind of the observer.

Umpire II takes the middle-ground approach (favored by DSM-IV) that what are labeled as balls and strikes are mental conceptions that reflect (albeit imperfectly) an external reality.

This debate as to the nature of the reality of balls and strikes has profound implications for understanding the nature of psychiatric classification. The nominalist versus realist debate resurfaced in various ways during the development of DSM-IV, as it necessarily must in the development of any psychiatric nosology. "Do psychiatric disorders exist as entities in nature, or do they arise as mental constructs created in the minds of the classifiers?'

The three quoted umpires represent three different answers to this question:

At one extreme, (Umpire I: "I call them as they are") are those who take a reductionistically realistic view of the world and its phenomena and believe that there actually is a thing or entity out there that we call schizophrenia and that it can be captured in the bottle of psychiatric diagnosis.

In contrast, there are the solipsistic nominalists (Umpire III: "There are no balls and no strikes until I call them") who might contend that nothing, especially psychiatric disorders, inherently exists except as it is constructed in the minds of people. For the past 30 years, this view has been expoused most clearly by Thomas Szasz.

DSM-IV represents an attempt to forge some middle ground between a naive realism and a heuristically barren solipsism. Like Umpire II, the DSM psychiatrists attempt to 'call them as we saw them" Most, if not all, mental disorders are better conceived as no more than (but also no less than) valuable heuristic constructs. Psychiatric constructs are not well-defined entities that describe nature exactly as it is. On the other hand, one must not follow Szasz in underestimating the clinical and research value of these constructs or in failing to recognize their consistency of presentation across observers, eras, and cultures. Certainly, mental disorders are constructs, but they are constructs with considerable practical and heuristic value in predicting course, family history, treatment response, and biological test results and indeed, in making what are sometimes life-and-death treatment and management decisions.

Frances, A., First, M. B., & Pincus, . D. (1995). DSM-IV guidebook (Chapter 2). Washington, DC: American Psychiatric Press.

Appendix E

What the Final Version of DSM-IV Rejected From the Cultural Recommendations

1. The cultural additions to the General Introduction and the 'Cultural Features' of individual disorders, based in a large body of scholarship, were cut down dramatically and their critical emphasis eliminated, typically resulting in superficial commentaries that are often empty of specific content.

2. The suggested texts for the introductions to the disorder sections were almost uniformly rejected, as were the changes to the Multiaxial Assessment section.

3. In addition, the Cultural Formulation was demoted to an Appendix, rather than placed after the Multiaxial Assessment at the front of the Manual, and its case illustrations were deleted.

4. The Glossary of Culture-Bound Syndromes, from which the additional term 'idioms of distress' was stricken, was joined to it {Cultural Formulation} in the same Appendix. The three Western 'culture-bound' syndromes' were dropped: Anorexia Nervosa, Chronic Fatigue Syndrome, and Dissociative Disorder Disorder. Simons & Hughes (1993) add the following to the Western list for consideration: Obesity, Type A Behavior Pattern, Nerves, and Petism.

5. Dissociative Trance Disorder and Mixed Anxiety-Depressive Disorder were not accepted into the body of the Manual, but rather listed in the Appendix on "Criteria Sets and Axes Provided for Further Study."

All of the above (except for the last part of Number 4) are taken from Lewis-Fernandez, R., & Kleinman, A. (1995, Sept.). Cultural psychiatry: Theoretical, clinical, and research issues. The Psychiatric Clinics of North America, 18, p. 439.

The last part of Number 4 came from Simons, R. C., & Hughes, C. C. (1993). Culture-bound syndromes. Culture, ethnicity, and mental illness, p. 81. Washington, DC: American Psychiatric Press.

Appendix F

Culture and Multicultural Diagnosis: How Culture Influences the Five Traditional Axes of DSM-IV

1. On Axis I, the clinical expression of symptoms is a function of the pathoplastic role of culture. Cultural factors may affect the list of categories (as in the case of the so-called culture-bound syndromes), the diagnostic definitions, and the qualifiers presented in the text.

2. On Axis II, disclaimers can be applied to practically every personality disorder when described in different cultural segments of the population. Same as Axis I: Cultural factors may affect the list of categories (as in the case of the so-called culture-bound syndromes), the diagnostic definitions, and the qualifiers presented in the text.

3. Even Axis III conditions may have some cultural variations. There is growing awareness of connections between ethnicity and specific physical disorders. For example, connections can involve genetic factors (as in the case of sickle cell anemias and African ethnicity) as well as social factors (as in the case of tuberculosis being facilitated by poor sanitary conditions, which are disproportionately more prevalent in some plurally deprived, ethnically identified minorities).

4. On Axis IV, the so-called psychosocial stressors reflect culturally determined circumstances of individuals and groups. The scaling of stressors and supports assumes an implicit cultural norm, and lists of stressors and supports may be culturally specific. According to Johnson-Powell (1996), there is no life events scale that includes racial/ethnic discrimination as a major and/or continuous stressor for minority group children or adults.

5. On Axis V, the overall functioning of the individual, its reporting and its assessment depend, to a large extent, on the cultural context of events continuously occurring in the life of persons and communities.

Alarcon, R. D. (1995, Sept.). Culture and psychiatric diagnosis: Impact on dsm-iv and icd-10. The Psychiatric Clinics of North America, 18, 455.

Mezzich, J. E. (1996). Culture and multiaxial diagnosis. In J. E. Mezzich et al., Culture & psychiatric diagnosis, p. 330. Washington, DC: American Psychiatric Press.

Appendix G

Self-Evaluation of Biases and Prejudices

The following has been somewhat modified from Paniagua's (1994, pp. 107-109) rating scale. Answer each of the following questions in reference to the following five groups: African Americans, American Indians, Asians, Hispanics, and Whites. Answer the statements on a piece of paper.

1. Have you had formal training with any of the groups? Which one(s)?

2. Do you have any cultural knowledge of any of them? Which one(s)?

3. As a parent, would you approve of your son or daughter dating anyone from the five groups? If so, which one(s)?

4. Would you date or marry a member of any of the groups? If so, which one(s)?

5. Do you have a personal or professional repulsion for or feel ill at ease with any of them? If so, which one(s)?

6. Have you been exposed to professional views of any of them? If so, which one(s)?

7. Are you familiar with the current literature (journals, books, periodicals) of any of them? If so, which one(s)?

8. Would you feel uncomfortable if you have a problem understanding any of them? If so, which one(s)?

9. Would you expect favorable therapy with any of them? If yes, which one(s)?

10. Would you expect a favorable therapeutic relationship with any of them? If so, which one(s).

Paniagua, F. A. (1994). Assessing and treating culturally diverse clients: A practical guide. Multicultural Aspects of Counseling Series 4. Thousand Oaks, CA: Sage.

Appendix H

Mental Status Examination (MSE) Exercise for School Psychologists

To help school psychologists appreciate why multicultural individuals may have difficulty with the MSE and to help them picture themselves in their place, some questions from Paniagua will be shared:

1. Assessment of Concentration and Vigilance: Subtract 7 from 100 and continue doing this until you get to the lowest number?

2. Assessment of Orientation: Can you name the location and the building you are in after you have experienced a panic attack in an unfamiliar city?

3. Assessment of General Knowledge: Can you name the capital of three countries in the Middle East, the distance from the sun to the earth, and the main differences between the U.S. flag and the Malaysian flag?

4. Assessment of thought Processes: Pretend that you are not fluent in Spanish and visit Mexico City; would you take time to think about what you want to say before you open your mouth and say it?

5. Assessment of Appearance: Pretend that you are a Puerto Rican taxi driver in Boston and have a 3:00 PM appointment with a therapist. You worked all day and did not have time to go home and shower and change. The therapist considers you depressed or psychotic. Would you return for a second appointment?

Paniagua, F. A. (1994). Assessing and treating culturally diverse clients: A practical guide. Multicultural Aspects of Counseling Series 4 (pp. 118-119). Thousand Oaks, CA: Sage.

Appendix I

Self-Awareness of Cultural Background

1. What is my cultural heritage? What was the culture of my parents and my grandparents? With what cultural group(s) do I identify?

2. What is the cultural relevance of my name?

3. What values, beliefs, opinions, and attitudes do I hold that are consistent with the dominant culture? Which are inconsistent? How did I learn these?

4. How did I decide to become a teacher or counselor {school psychologist}? What cultural standards were involved in the process? What do I understand to be the relationship between culture and education and/or counseling {school psychology}?

5. What unique abilities, aspirations, expectations, and limitations do I have that might influence my relations with culturally diverse individuals?

Locke, D. C. (1992). Increasing multicultural understanding: A comprehensive model, p. 2. Multicultural Aspects of Counseling Series 1. Newbury Park, CA: Sage.

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